NetworkNEWS
Illinois Department on Aging ■ Winter 2004

CLESE and the Task of Mutual Translation

Achieving the status of respected elder is a universal goal. Most cultures foster a dream of retirement in a comfortable environment, surrounded by family and community who are waiting to accept the wisdom and experience imparted by their elders.

But that is not always the way things turn out. Just ask Rosemary Gemperle, executive director of the Coalition of Limited-English Speaking Elderly (CLESE).

Photographs courtesy of the Coalition of Limited-English Speaking Elderly, Taiqin Dong photographer

"Immigration is a challenge at any age," she says. "And when the immigrant is older, dislocation is particularly tough.

"At a time when they had expected to achieve status as an elder who could share wisdom with the community, elders who speak little English are thrown into a world that is totally different from the world they left," says Gemperle.

"They have left behind home, language, customs, security. But hardest of all, they are expected to accommodate to a totally new world at a time when they have diminished resources to invest in that new world," she says.

And that, in a nutshell, is why CLESE came into existence. Recognizing that older immigrants, particularly those who do not speak English, may have needs that are different from the needs of older people in general, and that barriers to access for immigrants may exist, the late Robert J. Ahrens, commissioner of the Chicago Department on Aging, commissioned "The Ethnic Elderly Needs Assessment Survey" in 1988.

Indeed, the survey identified a lack of use of social services and provided a blueprint for CLESE, an agency that works with 40 ethnic groups to ensure that services for the elderly are adapted to the needs of older people in the state who do not speak English.

The characteristics of the 11 ethnic groups originally assessed by the survey are "markedly different," the report notes. They arrived here at different life stages and for different reasons. Clearly those who came willingly and with most preparation prior to arrival found coping much easier. Age, available family support, financial resources and education are also factors found to support adaptation.

But the most critical adaptive skill noted by the researchers is

(Continued on page 2.)

CLESE

(continued from page 1.)

the ability to speak English.

Further, the researchers note that some immigrant groups, such as the Cambodians, are also marked by a high rate of illiteracy in the native language. "This finding suggests that simply making bilingual materials available will not be sufficient to keep [some] informed of events or services."

"Translating materials is the easy part," says Gemperle. "It is much more difficult to translate attitudes, belief systems, history and cultural traditions. And that is our primary function: Translating the needs of the immigrant elderly to the mainstream and translating an understanding of their new land to the immigrant clients."

The 1,500 respondents in the initial study represented 11 groups: Cambodians, Chinese, Ethnic Chinese from Indo-China, Filipinos, Greeks, Koreans, Lithuanians, Mexicans, Polish, Puerto Ricans and Vietnamese.

Today, the list has changed somewhat. In 2003, there were an estimated 138,549 limited-English speaking elderly in Illinois, an increase of about 30 percent. And CLESE has focused services on a new immigrant group: ethnic Bosnians who first arrived in Chicago in 1993.

But the needs of immigrants have not changed.

'The most critical adaptive skill is the ability to speak English.'

— Ethnic Elderly Needs Assessment

"Elderly immigrants are, in some cases, receiving different treatment than native-born, English-speaking elderly," says Gemperle. "The reason for this is that they do not fit neatly into the existing service system for the elderly. Clearly, if we wish to serve elderly immigrants, we must work to change the rules to accommodate their needs."

(About the use of the word immigrants: "Each time I say immigrants, I also mean refugees and migrants not fluent in English," Gemperle explains.)

"Not only are elderly immigrants discriminated against in the delivery of aging services, but we have found that the elderly do not receive a proportionate share of services to immigrants. And, of course, the elderly in general are discriminated against in our youth-oriented society.

"So elderly immigrants have three strikes against them."

One of the most important findings of the original needs assessment was the reason why services were not being used.

"Contrary to popular beliefs, the most prominent reason is not language problems, fear of stigma, a sense of hopelessness, nor culturally inappropriate services, but the fact that the ethnic elderly subjectively believe they have children or relatives who can offer the services when they need them."

To remedy the situation, the researchers recommended "full use of the informal network of social support for the elderly."

And has that happened?

"I would say so," Gemperle

(Continued on page 4.)

Should We Rethink the Legacy We are Designing?

New Questions from Old Chestnuts

Director Charles D. Johnson
Illinois Department on Aging

"The country is growing older and more diverse!"

This, of course, is not news to most of us in the aging network. After being splashed by the age wave 20 years ago, we now tend to dismiss the familiar platitude each time we encounter it.

But maybe we are being too dismissive. Clearly, the changing landscape is not new to us and it usually introduces a shallow exposition that is similarly familiar.

But I submit that we may have been too quick to label and move on. Yes, we do understand the demographic data that predicts shifts in the composition of the population of older people in our state and our nation.

But regurgitating the data in shallow platitudes is one thing. Reacting to it in an intelligent way is entirely another. And, frankly, I do not think that we have done a good enough job of discussing the issues that these changes will bring to our network.

Clearly, the first item for discussion should be: How shall we define need? Many people in our professional field would target all services to the most needy.

And, if this becomes the accepted criterion, the next question must be: Should lack of language skills be considered a component of need? If so, what about immigrant status? And if inability to understand cultural norms is given weight, should that measure also be extended to native-born elderly people who have lived a lifetime of disadvantage?

The second question I would pose is this: During this time of tight budgets and dwindling resources, how shall we allocate our resources?

Other respected colleagues have expressed to me their fears that the increasing numbers of physically frail, minority and immigrant clients will shut the mainstream, middle class out of service entirely. They point out that it is not fair to deny the middle class access to information about services and programs, for crisis intervention and help with retirement planning.

This evokes another question: Should we attempt to be everything to everyone? And, if not, where and how should we draw the line?

And finally, let us go back to the beginning. Yes, we understand our population is changing. But what have we really done about it? Those of us in the public sector must remain acutely aware that the wheels move more slowly in government. So the plans that we make and the actions we take are likely to remain in place long after we have moved on. I think that it is probable that our reaction to population shifts will be the legacy that we leave for the next generation in our profession.

So, how do we want to be remembered?

I hope to leave a pattern of service that will keep the frail elderly in the communities in which they feel the closest connection, delaying or preventing institutionalization as long as possible.

And I want to be remembered as the leader of a Department that offers critical information and education to every older person in the state who needs service.

I hope we can expand eligibility for in-home services, and develop a reliable network of referral agencies for private-pay elderly people who need our assistance in referral.

I hope to leave a legacy of respect for the differences among population groups, as well as a mode for understanding and communicating openly with communities.

Change is a normal part of life; adapting to it is what service is all about. ■

CLESE

(continued from page 2.)

responds. “Each culture is different, of course, but each of the groups we have worked with has a distinctive informal support network.”

The first step in ensuring that all available supports are tapped is a CLESE policy to protect against the possibility that vital information is lost in translation.

“One of the most significant procedures that we have initiated is the use of co-case managers,” says Gemperle.

She explains it this way. When case managers from mainstream case coordination units visit the home of immigrants to conduct a determination of need, the case managers are usually unlikely to speak the family’s language and to understand the subtle and not so-subtle indices of cultural difference.

To counteract this, CLESE coordinates a demonstration with eight so-called ethnic agencies that focus on the needs of particular refugee communities. Then, working together, the mainstream case manager, accompanied by the co-case manager from the ethnic agency, assess the need together.

The importance of a co-case manager is highlighted in this report from Gemperle:

“A case manager in Region 2 went into the home of an Afghan family to do an assessment. The client was a man with congestive heart failure. He lives with his wife and two daughters, both of whom work outside the home. Because the case manager was not able to communicate with the couple, she left without doing an assessment.

“On a return visit, the case manager and a bilingual co-case manager from World Relief/DuPage suggested that the client may need in-hospital care for tests and treatment. He said that he could not do that because he didn’t want to leave his wife alone.

“It was then that the co-case manager discovered that he wasn’t the only one in the family who needed assistance. The client said he couldn’t leave his wife alone because she might try to kill herself. His wife had apparently attempted suicide on more than one occasion, including an incident in a refugee camp in Pakistan when she set herself on fire,” she says.

“In addition to being suicidal, the mother has not been able to hear since an accident when she was seven years old. The co-case manager took the woman to a medical clinic where she was seen by a psychiatrist and an internist. The first thing they did for her was get her a hearing aid so that, for the first time in over 50 years, she could have a normal conversation. The psychiatrist diagnosed her mental problems and prescribed medication, which has helped. World Relief got her into a woman’s group at their center. One of the daughters, suffering from post traumatic stress disorder, was referred to the mental health clinic.

“The father found relief from the in-hospital treatment he received; and when he was discharged, he received Community Care Program homemaker services.

“If there had not been a co-case manager involved, who

spoke the client's language, the most the family might expect was to receive homemaker services.

A significant change in state regulations has helped, Gemperle says. The Department on Aging allows ethnic organizations to target Community Care Program services to restricted populations.

There is, however, a long way to go. An example of cultural dissonance that remains, she says, is food service.

"Immigrants are not shut out of these services, but they might as well be. If the food is not familiar to their culture, they won't eat it."

Granted CLESE may have the moxie to translate this fact to the mainstream. But how can this American-born white woman convince the small ethnic agencies that she can help them meet their needs effectively?

"Our first job is to demonstrate that we have done our homework," Gemperle says. "We demonstrate that we understand the group's social history and the forces that led to immigration.

"Next, and just as important, we listen to them. It is critical that we understand their needs and how we can align available services to meet their needs."

Non-judgmental listening, important in all service interactions, is critical when the parties do not have similar frames of reference, she says. And to make sure that CLESE is up to the task, Gemperle has chosen her small staff with care. Beth O'Grady and Taiqin Dong, both from immigrant families, have the empathic bent and advocacy skills necessary, she says.

The three of them, working from the CLESE headquarters, 53 W. Jackson Blvd., in Chicago, are on a first-name basis with all of the 40 member agencies in the state that provide social and legal services to immigrants from 26 countries. This may mean, and often does, long days that include cultural events in the evenings and on weekends. It means determining the needs of each group and devising programs that meet them. It means having brochures describing available government services translated into the dominant foreign languages spoken in Illinois.

And it requires another kind of translation service, as well. "We must play a part in developing a mutual understanding between the elderly immigrant and the larger society," Gemperle says.

Department on Aging Director Charles D. Johnson agrees.

"Our greatest strength in the past has been our ability to offer transfers of resources among groups and between generations," he says.

"One of the tasks of CLESE, which is supported by the Department, is to ensure that these transfers will continue to happen."

Getting down to basics: Are

(Continued on page 6.)

Immigration in Illinois Changing

The scene in Illinois has changed.

Congress passed the Older Americans Act in 1966, after President Lyndon B. Johnson admonished, "What kind of a society are we if a rich country like ours can't take care of its old people?" That was before the wave of immigrants and refugees, so their needs weren't even considered when the new programs were developed.

At that time, white people of European background made up about 87 percent of the U.S. population.

In 1980, 70 percent of all immigrants lived in eight cities, including Chicago, and most immigrants in Illinois lived in Chicago. Today there are Mexican immigrant populations in every one of the 102 counties in the state.

Today people from 120 nations live in Illinois.

And by 2050, the U.S. Census Bureau predicts that people who are not of white European background will constitute about half of the population in this country. ■

(continued from page 5.)

most of the people in this population safe and happy?

In the original survey, researchers reported the vast majority prefers "living in this country rather than in their homeland," and "virtually all groups reported that the majority of their family members felt safe in their neighborhood."

Today the situation is about the same.

"Bosnian seniors are really homesick. In their dreams, it is always perfect back home. Now that it is safe, many have gone to visit. They come back to Chicago and report that the water still tastes wonderful, but nothing else is the same. Their houses are occupied by strangers, and people who returned to Bosnia to live are not happy. In spite of this, Bosnian seniors want to go home when they feel they are close to death. They want to be buried in the same cemetery as the generations before them."

A central concern of the initial survey is use of health facilities. In 1988, the researchers found that the Chinese and the Polish were most likely to report they had no place to go if they became sick or needed medical advice and had not seen a doctor in the past year.

Among the total sample, "a substantial number" reported needing — and not receiving — post-hospital supportive services and 43 percent had not visited a dentist in the past year.

Not surprisingly, one-third of this sample of people uprooted reported "fair" to "poor" mental health. Among the Vietnamese, Ethnic Chinese and Cambodians – groups that come to this country "by force of circumstances" in contrast to those who prepared for immigration, six out of 10 rated their mental health "fair" to "poor." In this group, 70 percent reported having no close friends and the researchers found these ethnic groups were "least aware" of the available services.

Is this still the case?

"It is still the case that refugees who did not elect to come here are more likely to have problems than those whose immigration is planned," says Gemperle. Flashbacks to the events that precipitated their escape are common, she says.

"Post-traumatic stress disorder is common among our clients," says Zumreta Kunosic, director of the Bosnian Herzegovinian American Community Center, 1257 W. Devon Ave., Chicago.

The well-organized Center offers a sophisticated network of support services for the northside community of about 26,000, including cultural, educational, business and civic opportunities available at many such centers. The list of service offerings, however, hints at the trauma experienced by the refugees from Bosnia and Herzegovina who survived genocide and concentration camps before arriving in the United States: Classes in domestic violence, crisis intervention, secondary resettlement and counseling are offered.

The stress disorder is so severe, says Kunosic, that 80 percent of the Center's clients experience it for the rest of their lives.

She described one client, age 55. Left for dead with a slit throat, she was rescued and sent

(Continued on page 7.)

CLESE

(continued from page 6.)

to this country with the first wave of medical evacuees from Bosnia in 1993.

"She recovered physically, but not mentally," Kunosic explains. "She stopped speaking. Her life is no longer outside, all is inside."

"After the physical scars disappear, the mental ones remain," she says. "As the years go by, many clients find they cannot express themselves in English and they need us more than ever. We try to help them understand that they are not alone."

Another case. "A 68-year-old woman was referred to us. All alone, with no family, she had purchased a one-way ticket to Bosnia and was ready to leave. Because of all that she had suffered there, she had no memory. She could not speak English. She could not sleep. And, like most immigrants, she was not used to opening up to strangers.

"We recognized that there was nothing for her to return to. And so, step-by step we helped her recover. 'We want you here; we want you to stay here,' we told her."

That was several years ago. And now?

"I have never seen such a happy person," says Kunosic. "She completed a citizenship class, she has learned English and attends meetings at the Center every Friday.

'Elderly immigrants have three strikes against them.'

— Rosemary Gemperle

Like other survivors, she has created a new group. This is her second home. She picks up the phone and calls us frequently. She belongs here."

The Bosnian community in Chicago, with about 2,000 families, is similar to other ethnic enclaves in the state. Although there are other communities throughout the state, Chicago remains the hub because application for citizenship is made in the city. And so Bosnian-Americans from the large community in Moline, say, may come to Chicago to apply for citizenship, to get help in translating materials and to bring elderly parents to meet others from the same generation.

They also come to Chicago for health care.

"Discrimination against immigrants in the health-care system has been identified and addressed to some degree, such as in Illinois' Language Assistance Act and the recent hearing in Chicago," Gemperle says.

"But we have recently discovered discrimination unique to immigrant seniors in the third of a three-year Alzheimer's Demonstration Project. The original purpose was to identify older people within five ethnic groups that have serious memory problems; get them assessed at Northwestern University Medical Center, then arrange for treatment or supportive services.

"Identifying people with memory problems was easy. Ethnic agency staffs know their clients intimately and know who has what problems. Our first hurdle was convincing families that serious memory problems are not a normal part of aging; and that something can be done. One by one, immigrant elderly agreed to go to Northwestern for a medical assessment. Because we had translators in the examining room, we learned what wasn't working. Much of the exam for dementia has a cultural bias toward native-born, English-speaking U.S. residents. The Northwestern doctors were not equipped for our clients, and expressed great frustration to our translators by their inability to conduct a 'normal' assessment," she says.

"A lot of the exam is the doctor listening to the patient. For instance, part of the exam is to listen for slurred speech, another is to obtain a medical history. A non-Chinese doctor may not be able to recognize slurred speech in a Chinese patient. Also, the Chinese person is unlikely to have a written medical history; and even the oral description of symptoms and

(Continued on page 8.)

CLESE

(continued from page 7.)

treatment are unlikely to be understood by a non-Chinese doctor," she says.

"A standard tool for measuring mental status, the Minnesota Multiphasic Personality Inventory, a mini-mental status exam, is known to be culturally biased. But it's what doctors learned to administer in medical school, and it's quick and easy, so they continue to use it. One of the questions on the exam is to spell the word 'world' backward.

'In Chinese? we asked.'

"We ended up finding ethnic doctors to administer the assessments for dementia."

Educational programs geared to aid mainstream people through the Medicare-Medicaid-private-insurance maze, also run into linguistic barriers.

Gemperle explains: "The Senior Health Insurance Program (SHIP) is looking for bilingual senior volunteers to learn about health-insurance options, and then inform immigrant seniors about the options. Project Choice has a similar program for using bilingual senior volunteers to teach other seniors about Medicare and Medicaid fraud.

"It's a model that doesn't work in immigrant communities because there are very few bilingual seniors in most ethnic populations. Bilingual young or middle-aged people are working and not available to volunteer. Now SHIP and Project Choice want the ethnic agency staff to do it — but don't want to pay them."

Federal civil rights law requires health-care providers to make services available to people in the language that they speak. But the law does not provide funding for that task.

Some problems, like elder abuse, occur in every community, in every racial, ethnic and economic group. But remediation is more difficult when cultural differences exist.

"In an abuse and neglect project that we manage for the City of Chicago, we see a type of emotional abuse that is unique to immigrant families," Gemperle says. "It involves the older person living with the adult children. Usually the in-law child no longer wants the older person in the home. The ethnic agency steps in to arrange other housing. It often involves telephone calls to the home country to find out what other options there are. Sometimes the ethnic agency collects money from the community to establish the older person in new housing, or to send him or her to another country to stay with a son or daughter."

Gemperle notes another difficulty in reporting neglect among immigrant families: "To report means that a mainstream elder abuse case manager comes into the home to document the situation. Not only are the elder abuse case managers unlikely to speak the family's language, their involvement impacts the relationship between the ethnic agency and the family, and may result in the client being punished by the family for bringing in the 'officials.'"

Is there one immigrant group that is more needy than others?

"I would say that the most recently arrived refugee group is always the neediest, and this has changed several times since I have been with CLESE," Gemperle says.

"But any group that does not speak the language of the majority is at a disadvantage."

And most English classes are not designed with older students in mind, Gemperle says. She offers this example: "Two ways the elderly are discriminated against in services to immigrants are in English as a Second Language (ESL) programs and the proposed new citizenship test.

"ESL curriculum and funding for adults is focused on English in the workplace. Most elderly are not in the job market, so the curriculum doesn't hold their attention. They want to know English in order to talk with their grandchildren, and to navigate in their communities. I went to a national conference for ESL teachers last year. I scanned the program book for anything to do with the elderly. There was only one session, something about older learners. When I went to the session, I found out that they define older learners as newly arrived adolescents.

"I visited the exhibition hall and talked with publishers. None of them knew of material for teaching ESL to seniors.

At the same time, the Immigration and Naturalization Service (INS) has revised the citizenship test to include reading and writing skills that require knowledge that is difficult to acquire without several years of ESL classes. Previously, the INS test required memorizing, so some seniors could do that. Now the test requires a comprehensive knowledge of English, including abstract thinking. I'm not saying that memorizing was the right way to do it, but at least seniors had a chance of passing the citizenship test. The test was to be pilot-tested earlier this year. I would be very surprised if seniors were a part of the pilot group."

The ability to speak English is important, Gemperle points out, and should not be dismissed because clients are elderly.

"That's age-discrimination, flat out," she says, "and like all the other prejudices, it is unfounded. As a matter of fact, Heide Wrigley, Ph.D., a literacy expert who has worked with us, reports there is no clinical evidence to prove that language cannot be learned at any age."

This is increasingly important, Gemperle says, because immigrant families are now more likely to scatter after arrival in this country, and the older members may be left behind.

"They need to know which bus to take and how to request electric service," she says.

"And most important, the elderly of all ethnic groups want to be able to understand what their children say." ■

Race, Ethnicity Affect Vaccination Rate, CDC Reports

Although flu and pneumonia have been cited as "key causes of mortality" in the over-65 population, the Centers for Disease Control (CDC) has noted "substantial disparities" in vaccination rates based on race and ethnicity.

In a weekly report issued in October, the CDC noted that 66 percent of the over-65 white population received flu shots and 57 percent of that group had pneumonia vaccinations during the 2000-to-2001 flu season. The number of minorities who received shots at the same time was much less: 48 and 33 percent respectively for non-Hispanic blacks and 54 and 32 percent for Hispanics.

The report also noted that the differences in vaccination rate by race and ethnicity, though decreasing slightly, has persisted over time and was noted even among older people most likely to be vaccinated, those with highest education levels and those who visited health-care providers frequently.

The analyses, conducted during the 2000 to 2001 flu season, included 9,435 non-Hispanic white, 1,341 non-Hispanic black and 1,133 Hispanic people over 65.

The CDC is addressing these disparities in two-year demonstration projects including one in Chicago. ■

Immigrants Moving Inland

About 60 percent of the 5.6 million foreign-born population who moved to the United States between 1995 and 2000 entered the country through six "gateway" states (Illinois, California, New York, Texas, Florida and New Jersey), an analysis of Census 2000 data shows.

At the same time, Illinois, along with New York and California, showed considerable net out-migration of their foreign-born populations to other states between 1995 and 2000.

"One of the major findings of Census 2000 was the overall size of the foreign-born population and its presence in areas outside the traditional immigration gateways," said Census Bureau Director Louis Kincannon.

"This movement reminds us that opportunities abound throughout our country."

The new Census Bureau report, "Migration of Natives and the Foreign Born: 1995 to 2000," examined Census data to compare migration patterns for natives (people born in the United States) with people born abroad. Among the findings:

- Domestic migration patterns of foreign-born and native migrants were similar, with common destinations.
- Between 1995 and 2000, California's net out-migration rate to other states of foreign-born people was higher than its net out-migration rate for natives (22.6 people lost per 1,000 native residents in 1995).
- Some states and counties in the Midwest had net domestic out-migration of natives but net domestic in-migration of the foreign-born population. For example, Nebraska and Kansas had native net out-migration rates of 13.1 and 5.2, but foreign-born net in-migration rates of 101.0 and 47.6, respectively. ■

Novels About the Immigrant Experience

"Bonesetter's Daughter," by Amy Tan

"Bread Givers: A Struggle between a Father of the Old World and a Daughter of the New World," by Anzia Yezierska

"Brick Lane," by Monica Ali

"Domestica: Immigrant Workers Cleaning and Caring in the Shadows of Affluence," by Pierrette Hondagneu-Sotelo

"Hawaii," by James Michener

"House of Sand and Fog," by Andre Dubus II

"Hunger" by Lan Samantha Chang

"Leslie," by Omar R. Tyree

"Letters from Rifka," by Karen Hesse

"Lost in America: A Journey with My Father," by Sherwin B. Nuland

"Master Butchers Singing Club," by Louise Erdrich

"Native Speaker," by Chang-Rae Lee

"Nowhere Man," by Aleksandar Hemon

"Stanislaske Brothers: Mikhail and Alex," by Nora Roberts

"The Jungle," by Upton Sinclair

"The Namesake: A Novel," by Jhumpa Lahiri

"The Tortilla Curtain," by T. Coraghessan Boyle

"Tis: A Memoir," by Frank McCourt

"White Teeth," by Zadie Smith

"Woman Warrior: memoirs of a Girlhood among Ghosts," by Maxine Hong Kingston

"Whiteness of a Different Color: European Immigrants and the Alchemy of Race," by Matthew Frye Jacobson

Studies Find Unequal Treatment in Health Care

Racial and ethnic disparities in medical treatment have been found in a number of studies published recently in medical journals.

Discrimination Hurts, Literally

It hurts to be a member of a minority group, a new study has found. African-Americans and Hispanics are more likely to experience pain — and less likely to receive relief from it, even if they are under the care of a doctor, a study at the University of Michigan has found.

Carmen Green, a pain-management specialist who led the study, found that African-Americans and Hispanics experienced greater burden of pain than the white patient even when the data was controlled for income, language proficiency and insurance.

According to Julianne Malveaux, author of an opinion piece in USA Today in October, the study suggests that the "medical establishment can do better" in treating the pain of minority patients.

Remedial Surgery More Common for Whites

In another study, published in October in the New England Journal of Medicine in October, it was found that rates for total knee replacement surgery in the Medicare population vary significantly by race, ethnicity, region and gender.

Black men across the country were the least likely to receive the surgery, which is the most common joint replacement operation in this country. While 4.82 white men per every 1,000 received knee replacements, the surgery was performed on 3.46 Hispanic men and only 1.84 black men per 1,000.

The annual rate of knee replacement was also found to be higher for non-Hispanic white women, 5.37 procedures per 1,000, than for Hispanic women, 5.37 per 1,000 and black women, 4.82 per 1,000.

The study was conducted by researchers from Dartmouth Medical School by examining 430,726 Medicare claims for the procedure, known as arthroplasty, during the three-year study period.

In an editorial accompanying the study, two leaders of the Robert Wood Johnson Foundation, Dr. Risa Lavizzo-Mourey and James Knickman, recommended three remedial steps: identifying "effective, practical approaches" for providers to use in reducing racial disparities, requiring providers, insurers and payers measure racial and ethnic disparities within the population they treat, and having more timely data collection. What is needed now, they wrote, is "a comprehensive set of steps for action…to set the nation on a path that will eliminate these disparities in health care."

Black Women Lack Heart Care

Black women are twice as likely as white women to have heart disease — but less likely to be given a standard treatment for it, a study has found.

The greater incidence of disease is related to a higher rate of risk factors such as high cholesterol and high blood pressure, according to a study in Circulation, a journal of the American Heart Association.

The four-year study by researchers at Brigham and Women's Hospital in Boston and the Harvard School of Health, looked at 62,699 women across the nation, 8 percent of whom were black.

Black women were 10 percent less likely to get aspirin and 27 percent less likely to get statins, cholesterol-lowering drugs, the researchers reported. As a result, black women are at great risk, the researchers wrote. ■

Black Men Most Vulnerable to Stroke

Black men are more likely to have a stroke than white men — and less likely to survive stroke, researchers have found.

Twice as many blacks as whites experience a stroke each year, and stroke patients who are black are more likely to die as a result, the study reports.

The study, "Racial differences in survival post cerebral infarction among the elderly" is reported in the current issue of "Research Activities" of the U.S. Department of Health and Human Services.

Among the important findings: Elderly blacks are 6 percent more likely than whites to die within three years after a stroke. The difference was exacerbated among the so called "young aged," those from 65 to 74. In this group, blacks were at a 20-percent greater risk of death. Black women in this age group had a similar disadvantage, but the difference began to disappear in older age categories.

The researchers examined three year post-stroke survival rates among elderly white and black patients on Medicare who were hospitalized for stroke in 1991. Stroke patients who were black were more likely than white stroke patients to have a history of hypertension, diabetes, disability and prior stroke than were white patients hospitalized for stroke, the researchers found.

The study, which appeared in the journal "Neurology," was based on Medicare data, rather than clinical studies, and so it is not possible to attribute differences in survival to biological differences related to race, the authors caution. ■

For more information about disparities in health care:

- Chicago Health Outreach Project, 1-773-275-2600
- Health and Disabilities Associates, 1-312-223-9600
- National Caucus and Center on Black Aged, Inc., 1-202-637-8400
- Office for Civil Rights, Department of Health and Human Services, 1-312-886-1145

Printed by Authority of the State of Illinois 6M, March 2004 Printed on Recycled Paper

Published by the Illinois Department on Aging, ***Network News*** is a quarterly publication distributed free to the agencies and organizations in the Aging Network, older adults, members of the Legislature, the media and other interested people.

NetworkNEWS

Governor Rod R. Blagojevich
Director Charles D. Johnson

Illinois Department on Aging
421 East Capitol Avenue, #100
Springfield, IL 62701-1789

www.state.il.us/aging

PRESORTED STANDARD
U.S. POSTAGE PAID
Springfield, IL
Permit No. 427